STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155102	A. BUILDING 02 B. WING	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	635 OAKHILL AVENUE PLYMOUTH, IN46563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/15/11 Facility Number: 000041 Provider Number: 155102 AIM Number: 100275400 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	This one story facility determined to be of Type V (000) construction and was fully sprinklered. The building was constructed in three phases: the original building was constructed in 1968 and includes the Terrace wing, ICF I and ICF II; ICF III and the Skilled wing were completed in 1974 with the Orchard wing and main hall added in 1985. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 135 and had a census of 100 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/21/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 7 shower room doors would latch into the door frame or were provided with a device that exerts at least 5 pounds of pressure to keep the door tightly closed. This deficient practice could effect occupants in and near the # 7 shower room including staff, visitors and residents. Findings include: Based on observation on 06/15/11 at 3:00 p.m. with the maintenance supervisor, the corridor door to the	K0018	**K018 NFPA Life Safety Code Standard** The deficient practice could affect occupants in and near the #7 shower room including staff, visitors, and residents. To correct the deficient practice an automatic door closer was placed on #7 shower room door immediately. To ensure the deficient practice does not recur all doors in the facility were assessed for the need for automatic closer. All doors found to be in compliance. The corrective actions will be monitored by the Maintenance Supervisor and/or designee. The QA tool labeled "Facility Door Audit" (Attachment #1 – 2 pages) will be completed by the Maintenance	07/17/2011

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	number seven shower room was not equipped with a latch which latched into the door frame or a device to provide at least five pounds of pressure to keep the doors closed. The maintenance supervisor stated at the time of observation, he was not aware of the problem. 3.1-19(b)		Supervisor and/or designee on a monthly basis to ensure the deficient practice does not recur. Changes will be completed by 7/17/2011	
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 3 kitchen doors separating a hazardous area from the main corridor was free from impediments to closing, and latched to prevent the passage of smoke.	K0029	**K029 NFPA 101 Life Safety Code Standard** The deficient practice could affect residents, visitors, and staff in and near the kitchen. To correct the deficient practice the dead bolt lock was removed from the kitchen door immediately. The door	07/17/2011

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	This deficient practice could affect residents, visitors and staff in and near the kitchen. Findings include: Based on observations with the maintenance supervisor on 06/15/11 at 2:40 p.m., the middle door of three doors to the kitchen had a dead bolt lock which when engaged prevented the door from closing and created a one inch gap. The door also lacked a mechanism to positively latch the door to the door frame. The maintenance supervisor acknowledged the problem at the time of observation. 3.1-19(b)		is able to be closed and latched appropriately. To ensure the deficient practice does not recur all doors in the facility were assessed for the need to remove any unnecessary devices that impede them for latching appropriately. All other doors found to be in compliance. The corrective actions will be monitored by the Maintenance Supervisor and/or designee. The QA tool labeled "Facility Door Audit" (Attachment #1 – 2 pages) will be completed by the Maintenance Supervisor and/or designee on a monthly basis to ensure the deficient practice does not recur. Changes will be completed by 7/17/2011	
K0052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on interview and record	K0052	**K052 NFPA 101 Life Safety Code**	07/17/2011

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	review, the facility failed to provide consistent evidence of the testing, maintenance and inspection of 1 of 1 fire alarm systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-1.1.1 requires fire alarm systems shall be inspected, tested and maintained. This deficient practice effects all residents, staff and visitors in the event of an emergency. Findings include: During the alarm systems record review with the maintenance supervisor on 06/15/11 at 10:50 a.m., the number of documented devices inspected annually by Safe Care (03/30/11) and again by Communications Co. (03/26/10) was not consistent from inspection to inspection regarding the number of devices inspected within the facility. The maintenance supervisor stated at the time of record review, he did not have the code to their smart system controls to confirm the actual numbers of		**Standard** The deficient practice has the potential to affect all residents, staff, and visitors in the event of an emergency. To correct the deficient practice vendor, Safe Care, came out to the facility on 7/5/11 and 7/6/11 and performed an annual inspection and audit of the fire system (See attachment #2 – 5 pages). Effective 7/11/11, Safe Care, will be the only service company to provide the annual testing as well as sensitivity testing. Vendor, Communication Company, will no long provide any testing to fire system. The corrective actions will be monitored by the Maintenance Supervisor and/or designee. The QA tool labeled "Annual Preventative Maintenance Report" (Attachment #3 – 1 page) will be done annually to ensure the test is done and is accurate. Changes will be completed by 7/17/2011	

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	each device due to a dispute between the two providers. 3.1-19(b)			
K0062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all of the residents, staff and visitors, if the sprinkler system had to be shut down because	K0062	**K062 NFPA 101 Life Safety Code Standard** The deficient practice has the potential to affect all of the residents, staff, and visitors, if the sprinkler system had to be shut down because a proper sprinkler was not available as a replacement. To correct the deficient practice our vendor, Safe Care, will supply the facility with the required replacement sprinklers representative of the types and temperature ratings of the system sprinklers by 7/17/2011. The corrective actions will be monitored by the Maintenance Supervisor and/or designee. The QA tool labeled "Monthly Preventative Maintenance Report" (Attachment #4 – 1 page) will be completed monthly by the Maintenance Supervisor and/or designee. Changes will be completed by 7/17/2011	07/17/2011

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	a proper sprinkler wasn't available as a replacement. Findings include: Based on observation with the maintenance supervisor on 06/15/11 during the tour at 3:15 p.m., there were no pendant sprinklers in the spare sprinkler cabinets for the corridors. The maintenance supervisor stated at the time of observation, he was not fully aware of the requirement and he was short on sprinkler heads. 3.1-19(b)			
K0064 SS=D	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 ABC portable fire extinguisher in the main electrical room had pressure gauge readings which were in the operable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic	K0064	**K064 NFPA 101 Life Safety Code Standard** The deficient practice was not in a resident care area but could affect any staff in the main electrical room in the event of an emergency. To correct the deficient practice our vendor, Allied Safety, came out to recharge the extinguisher. Our vendor comes out to the facility every 6 months to perform	07/17/2011

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	155102	A. BUILDING 02 B. WING	06/15/2011

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	monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (g) Pressure gauge reading or indicator not in operable range or position, shall be subjected to applicable maintenance procedures. This deficient practice was not in a resident care area but could affect any staff in the main electrical room in the event of an emergency. Findings include: Based on an observation with the maintenance supervisor on 06/15/11 at 3:15 p.m., the gauge on the ABC portable fire extinguisher in the main electrical room indicated the extinguisher was undercharged. This was acknowledged by the maintenance supervisor at the time of observation. 3.1-19(b)		recharging of the extinguishers. The corrective actions will be monitored by the Maintenance Supervisor and/or designee. The QA tool labeled "Fire Extinguisher Check Log" (Attachment #5 – 3 pages) has and will be completed monthly on all extinguishers in the facility. The vendor will also be re-educated to on the locations of all fire extinguishers in the facility so that all are checked and recharged per regulation. Changes will be completed by 7/17/2011	

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K0067 SS=E	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 67 of 82 rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors in ICF-1, ICF-2, ICF-3, Terrace wing and the residential hall. Findings include:	K0067	**K067 NFPA 101 Life Safety Code Standard** We have applied for a continuing annual waiver (please see attached documentation).	07/17/2011

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	Based on observation on 06/15/11 between 1:15 p.m. and 2:45 p.m. with the maintenance supervisor, the resident rooms located on ICF I, ICF II, ICF III, the Terrace wing and the residential hall were using the egress corridors as a return air system. Heating and cooling is supplied by vents in the resident rooms and rely on the corridors for return ventilation. The maintenance supervisor acknowledged the deficiency and stated he was not aware of the problem. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure the load for the monthly load test for the generator was at least 30% of the nameplate rating for 12 of 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires	K0144	K0144 NFPA 101 Life Safety Code Standard **Finding 1.** The deficient practice has the potential to affect all residents, staff, and visitors. To correct the deficient practice our	07/17/2011

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	155102	A. BUILDING 02 B. WING	06/15/2011

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	monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of monthly load test record documentation with the maintenance supervisor from 10:40		generator service vendor came to the facility to speak with the Administrator and Maintenance Supervisor about the generator and educated us on how to calculate the 30% test. Another vendor, Safe Care, is scheduled to perform a load bank test before 7/17/2011. Instructions were also printed out for the Maintenance Supervisor from our Electronic Preventative Maintenance database. (Attachment #6 – 3 pages; 2 are instructions and 1 page is return demonstration done by Maintenance Supervisor on 6/27/2011). We have also changed the Emergency Generator Monthly Log Test to reflect all required data (Attachment #7 – 1page). The QA tool labeled "Emergency Generator – Monthly Test Log" (Attachment #7) will be completed by the Maintenance Supervisor and/or designee on a monthly basis to ensure regulation is being followed. Changes will be completed by 7/17/2011 **Finding 2.** The deficient practice could affect all residents, staff, and visitors in the event of an emergency. To correct the deficient practice the Maintenance Supervisor will perform the missed 90 minute emergency light test before 7/17/2011. The	

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	a.m. to 12:10 p.m. on 06/15/11, monthly logs for the period of July 2010 through June 2011 show the emergency generator ran for at least thirty minutes each month for the 12 month period but the percentage of load capacity was not documented. Based on interview at the time of record review, the maintenance supervisor stated he was not aware of the requirement and did not know how to determine 30 percent of the load capacity. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a		facility will also have a Emergency shut off device installed by 7/17/2011 by vendor, Safe Care. The QA tool labeled “Annual Preventative Maintenance Report” (Attachment #3) will be completed annually to ensure compliance with regulation for the 90 minute emergency light test. Changes will be completed by 7/17/2011	

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	remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors in the event of an emergency. Findings include: Based on review of the Generator Maintenance records on 06/15/11 at 11:25 a.m. with the maintenance supervisor, there was no documentation available which indicated the horsepower rating of the generator engine provided. Based on interview with the maintenance supervisor during record review, he stated no remote			

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	shut off device existed for the generator. The maintenance supervisor indicated the generator was installed before 2003. 3.1-19(b)			